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ARE DELUSIONS DANGEROUS UNDER ALL CIRCUMSTANCES?

There is reliable evidence to suggest that the delusions that are characteristic of psychotic disturbances are causally related to emotional disorders, and such neuroses, and are identifiable by the phenomenological content of hallucinations. “Delusions are viewed as transformations of the structure of experiencing... A dialectic exchange is needed between prototypical models generated by phenomenological inquiry and empirical, operational validation of testable aspects of such models.” (Bovet, Parnas. 1993)

This treatise suggests evaluating a new model of concomitant treatment for psychotic, schizophrenic, PTSD and other subjects who live with the experience of Auditory Verbal Hallucinations (AVH’s). This new approach is psycho-emotional therapy. A similar evaluation has been previously conducted by Buchanan A1, Reed A, Wessely S *et al* (1993), and reported in a paper titled “Acting on delusions. II: The phenomenological correlates of acting on delusions.”

It should be noted that pursuit of the Christian religion is delusional, especially if you utilise the vocabulary of schizophrenia symptoms. Praying is the act of “thought broadcasting”, or relies on telepathy, a process of ‘thinking out loud’ that is exactly the same as a schizophrenic would if they were engaging their VH or AVH. Singing in church, believing that God is listening or will hear, is also plainly delusional. More than 6,500 years of philosophy, our highest quality structured and rigorous thought investigations, have revealed that there is no evidence of God. One can argue that he/she does not exist. But at a clinical level, there certainly is no basis upon which to claim that God is hearing the singing. Only the person next to you, or perhaps in front of you, can hear your singing, and they clearly are not God. And finally, just believing that God exists, in a clinical, psychiatric sense, is delusional.

The apparatus of this new approach is to, 1) firstly explicitly agree with the patient that their beliefs are delusional, that is, they do not withstand rigorous analysis as plausible, and no other individuals can or will support their interpretation of the world. 2) Secondly, having agreed to the erroneous nature of their beliefs, the patient is guided to the WWW online mental health forums, where they can enquire and find support and feedback, and re3ality test their faulty beliefs.

Once this second activity is underway, the patient is advised to record 1st person transcripts of the dialogue of their hallucinations, the likely fuel for their delusional thought constructions. “Delusions acquire a schizophrenic quality when ontological (i.e., universal) elements of the discourse between the locutor and the Other dominate at the expense of the worldly elements.” (Bovet, Parnas. 1993)

It is noteworthy that this idea involves not just the failure to repel the delusional thinking, but to ‘buy into it’ and actively explore it at face value, *prima facie* as it were. In order to accomplish this, a further discussion and agreement needs to take place between the clinician and the subject. After developing a ‘library’ of 1st person transcripts, an investigation of the data (transcripts) should ensue, resulting in an agreement about the different nuances within the data. Namely, identifying that the data consistently identifies the subject as good, kind, truthful, compassionate etc, in contrast to the AVH’s that hate, criticise, and demand unreasonably. The subject will always achieve “the higher moral ground”. It is this result that makes this treatment approach so efficacious.

Hallucinations are generally defined as perceptions that occur in the absence of corresponding external stimuli. “Perception is the awareness of objects and relation in the surrounding environment in response to the stimulation of peripheral sense organs as distinct from the awareness that results from memory. Impairments in perceptual apparatus set the stage for delusions, hallucination, illusions and misinterpretations of reality….Illusions - perceptual distortion in the estimation of size, shape and spatial relations of objects.” (Barberio 2000).

Once the above pre-requisites are achieved, there is a reported occurrence of dissipation of conviction. “When action was described by the subjects themselves, acting was associated with: being aware of evidence which supported the belief and with having actively sought out such evidence; a tendency to reduce the conviction with which a belief was held when that belief was challenged; and with feeling sad, frightened or anxious as a consequence of the delusion.” (Buchanan, Reed, Wessely *et al*

1993). Even if this fails to occur, a preliminary study suggests significant reliance upon psychopharmacology and an associated decrease in co-morbidity.

The final aspect of this potential therapeutic approach relates to the diagnostic criteria applied to individuals presenting with symptoms that would facilitate this idea (approach). Kendler (2016) points out that in a review "the criteria for schizophrenia from 6 modern US operationalized diagnostic systems….modern criteria favoured symptoms over signs." The impact of this is that while the DSM V sets the standard criteria necessary to result in a psychotic diagnosis, meeting the criteria necessarily facilitates an opportunity to test and measure the efficacy of this novel treatment. Quantifiable efficacy would be easy to measure. It is inherent in the self-reported wellbeing of the patient (use a self-report scale), additionally quantifiably measured in declining additional or increased medication in the face of persistent AVH's, due to improved and resilient emotional and sentient wellbeing.

Results achieved experimentally demonstrate achievement of a substantial rise in self-esteem, that extinguishes concerns of suicide, and alleviates susceptibility to stress. This approach to management and coping makes the subject highly resilient to the detrimental impact of AVH's. The net outcome is a 'bullet-proof' subject, who relies on pharmacology much less, alleviating the factors that cause co-morbidity, and the presentation of a patient who can report satisfactory baseline feelings, from noticeably improved responses to the lethal symptoms.

BACKGROUND OF THE SCIENCE AROUND AVH'S

The following argument is background to the novel treatment approach outlined above. It is provided in the interest of balance, but the strength of these counter arguments should not detract from the potential massive benefits available from the above therapeutic technique.

New ontological insights usually combine well with increasing quantitative (clinical) data to more accurately describe diagnoses that featuring AVH symptoms. Our mental health science is fortunately effective, reasoned skilfully by Mary Boyle in "Schizophrenia A Scientific Delusion?" [1993]. With respect to the detail of the scientific framework we use to understand AVH's, we have only rudimentary understanding of how to stimulate the human brain using electrodes or TCDMS to produce illusions, but we have no knowledge of how to produce hallucinations.

Without being able to incite or reproduce the neurological, executive and cognitive dysfunction, we cannot attempt to reproduce hallucinations in order to begin acquiring the requisite evidence from which to produce null hypotheses, allowing analysis of the data to validate the experimental data into facts.

However, even if we did have sufficient skills, grounding and tools necessary to experiment with hallucinations, such skilful manipulation of our brain would only produce illusions (Arzy, Seeck, Ortigue et al 2006) or "pseudo-hallucinations", and not the hallucinations intended. For an article that inversely misunderstands the difference between illusions and hallucinations please see article referenced below: "Creating Hallucinations Without Drugs Is Surprisingly Easy" (BEC Crew 2018).

However, it can be argued that excluding bizarre unrealistic explanations for AVH's results in science that tends to ignore the primary symptoms presented in the first hand testimonials of the patient, and these testimonials represent high fidelity, complete (extensive) first hand access to the data. There is very little evidence to empirically support the hypotheses that the experiences of schizophrenics, the disassociated, PTSD sufferers etc are hallucinatory, other than a lack of stimulus.

Pursuant to this, the information age has created a brand new investigative / user-centric (data) resource , namely the online mental health forums. There are quite a few forums dedicated to schizophrenia / psychosis and hearing voices. These forums provide an anonymous environment moderated by accredited professionals where privacy is diligently guarded through secure policies and protocols, subsequently enforcing standards that ensure participation with safety and professional balance.

These sites have become repositories where participants with similar diagnoses and symptoms share details of esoteric experiences, especially Auditory Verbal Hallucinations (AVHs) and they facilitate publication of details describing the plots, themes and idiosyncrasies of the author's delusions. These personal but central experiences can be safely and beneficially exchanged and enable empathetic appreciation and non-judgmental like-mindedness from a quorum of opt-in peers who are "experts by experience".

Legitimate science cannot accommodate or provide regard to any extravagant and bizarre explanations commonly provided by patients to account for their extranormal subjective experiences. It is unpalatable to scientists, but patients often invoke paranormal interpretations for symptoms that are evident in testimonials on these sites.

So the conventional model of understanding is arguably incomplete because 1) we cannot produce hallucinations experimentally in order to defeat null hypotheses, 2) and because of their 'nature' we have a perpetual inability to measure them empirically. This in fact makes our knowledge qualitative at best, and represents a shortfall in the conventional scientific model we use.

There are more issues though in conventional models. A patient asked about their voices may be attempting to summarise 448 hours of symptoms (hallucinations, AVH's) into a 30-60 second summary, so there it is essentially impossible for them to relate the character of their distress.

A CHALLENGE TO CONVENTIONAL MODELLING

The following issues are provided to counter the balance provided above. These elements of uncertainty are provided to give a sympathetic and empathetic voice to somewhat estranged individuals who have a diagnosis that will be primarily be treated with pharmacology that will detract 20 years from their lifespan, lead to much higher smoking rates, l;ead to obesity, and cause overwhelming feelings of distress via side effects.

Following are some phenomenological features that are concentric to the new parallel treatment approach outlined at the top of this treatise. You will notice immediately that these are features not commonly used to measure phenomenology. However, they are assuredly features that are foremost in the considerations of the patients (provable in the online testimonials). Following are a small number of examples of questions that will reduce reliance on psychopharmacology:

1) What proportion of an individual's voices implicate aliens/demons/ghosts/beings etc, telepathy, and other paranormal explanations?
2) What proportion of AVH's state that "your friends hate you?"
3) What proportion of AVH's state that they "work in shifts?"
4) What proportion of AVH's state that they "demand suicide" explicitly?
5) What is the frequency / sum and the repertoire of command hallucinations that express demands? (eg: hurt someone / hurt yourself / shoplift / write this on a Facebook page / stop eating – the food is poisoned / don't attend something / do not do ta particular thing etc)
6) What proportion of AVH's state their names?
7) What proportion of AVH statements can be negotiated? (and what are the salient characteristics or elements of negotiable demands made by voices [AVH's]?)
8) What proportion of AVH's ask questions? And what questions are frequently asked?
9) What proportion of AVH's are measurably less educated than their victim, evident in lower numeracy skills, absent (response to enquiries) knowledge of their weight, refusal to answer whether they exercise, refusal to answer how they maintain health, will not respond to requests for sources of information used in poisonous malevolent statements of negative valence?
10) How commonly do the AVH's either refuse to provide definitions of words they use, or do not know the definitions known by the patient?
11) Will AVH's provide their own answers to an online psychopathy measurement tests? (Contrast with demonstrated willingness of the patient)
12) In the absence of responsiveness to these engagement approaches, are the AVH's irrational, or just spiteful and hateful?
13) With regards to misattribution - why is the subject of the AVH's proven to be a kind, sympathetic, caring and compassionate individual, but in misattribution, they apparently are rude, indignant and hostile, an antithesis of themselves?
14) I suggest that there is no evidence of any person having the capacity and propensity to hate themselves, to the same degree that AVHs hate their victims. No secondary literature supports the assertion that an individual, no matter how critical, has the enmity expressed by their AVH's. It is intrinsic that we have and know the reasoning that underpins our behaviour and attitudes/responses, and it is unreasonable to accuse ones-self of misattribution or subvocalization resulting in such extreme malevolence, sadism, unforgiving abuse and self-persecution. People do not blame themselves with the emphasis and voracity that AVH's blame their host.

PROVABLE COUNTER, COUNTER ARGUMENT

With regards to engagement as a coping strategy, if the only things in the cosmos that have voices and talk are life-forms, is there danger in asking the voices what they are (what 'species' they are), then for the sake of achieving peace and avoiding potentially lethal hatred, testing whether there is great risk in dealing with them at face value?

Ongoing refusal to engage (especially with provision of names and species requests for example) will unavoidably and most certainly have a two results 1) increased discrediting of the negative valence of the AVH's (possibly to a state of eventual ultimate irrationality), and 2) increasing silence, from the vacuum of answers. Any ongoing and subsequent attempts by AVH's to influence or demand compliance from the victim is therefore most likely to fail, due to attenuated omnipotence and an increasing lack of credibility.

A personal statement: I am a person who lives with the experience of hearing voices, and I am a clinical patient that has experienced psychosis a number of times. I feel compelled to have written this argument about an alternative perspective to the science based not on my own singular experiences, but on the weight and substance of the testimonials and statements of individuals seeking solace from the experience of living with AVH's.

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